BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the adoption of Rules I)	NOTICE OF PUBLIC HEARING
through VII, and the amendment of)	ON PROPOSED ADOPTION
ARM 37.86.2901, 37.86.2907,)	AND AMENDMENT
37.86.3002, and 37.86.3005 pertaining)	
to Medicaid reimbursement for)	
inpatient and outpatient hospital)	
services)	

TO: All Interested Persons

1. On May 11, 2006, at 3:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption and amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on May 1, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be adopted provide as follows:

RULE I OUTPATIENT HOSPITAL SERVICES, CARDIAC AND PULMONARY REHABILITATION SERVICES (1) Coverage for medically necessary outpatient cardiac and pulmonary rehabilitation services is effective January 1, 2006.

- (2) All cardiac and pulmonary rehabilitative services must be medically necessary and prior authorized by the department's designated review organization.
- (3) The following conditions are contraindications to cardiac or pulmonary rehabilitation, and except as provided in [Rule IV], patients with one or more contraindications are not eligible for cardiac or pulmonary rehabilitation:
- (a) severe psychiatric disturbance including, but not limited to, dementia and organic brain syndrome; or
- (b) significant or unstable medical conditions including, but not limited to, substance abuse, liver dysfunction, kidney dysfunction, and metastic cancer.

AUTH: <u>53-2-201</u>, <u>53-6-111</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE II OUTPATIENT HOSPITAL SERVICES, CARDIAC REHABILITATION SERVICES (1) Cardiac rehabilitation services are limited to the following:

- (a) Up to three visits per week for eight weeks, limited to the following cardiac events and diagnoses eligible for cardiac rehabilitation benefits:
 - (i) myocardial infarction;
 - (ii) coronary angioplasty;
 - (iii) heart-lung transplant;
 - (iv) valvular surgery;
 - (v) congestive heart failure; and
 - (vi) heart-lung transplant.
- (b) Services are limited to Phase I cardiac rehabilitation provided in the hospital immediately following the cardiac event or diagnosis, and, after hospital discharge, Phase II services if they are initiated within four months of the event or diagnosis and require EKG monitoring with a medical doctor present in the same building.

AUTH: <u>53-2-201</u>, <u>53-6-111</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE III OUTPATIENT HOSPITAL SERVICES, PULMONARY REHABILITATION SERVICES (1) Pulmonary rehabilitation services are limited to the following:

- (a) a maximum of 36 hours over a period not less than two weeks and not more than six weeks, limited to one of the following diagnoses:
 - (i) persistent asthma;
 - (ii) emphysema;
 - (iii) chronic bronchitis;
 - (iv) bronchiectasis;
 - (v) interstitial lung disease; and
 - (vi) chronic airway obstruction.
- (2) If applicable, the patient must have ceased smoking or be in a smoking cessation class.
- (3) The patient must have a referral to individual case management (ICM) before receiving pulmonary rehabilitation services.
 - (4) The following pulmonary rehabilitation services are not covered:
- (a) education, treatment, and therapies that are not individualized to a specific patient need or are not an integral part of the treatment session;
- (b) routine psychological screening and treatment where intervention is not indicated;
 - (c) films/videos;
 - (d) duplicate services;
 - (e) maintenance care when there is no expectation of further improvement;
- (f) treatment that is not medically necessary because the patient requires a general strengthening and endurance program only; and
- (g) treatment that is not medically necessary because the patient is at an early stage of pulmonary disease as demonstrated by a lack of significant findings in diagnostic testing.

AUTH: <u>53-2-201</u>, <u>53-6-111</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE IV OUTPATIENT HOSPTIAL SERVICES, CARDIAC AND PULMONARY REHABILITATION, WAIVER OF SERVICE LIMITATIONS

(1) The service limitations provided in [Rule II] and [Rule III] may be waived for extenuating circumstances on a case-by-case basis by the department.

AUTH: <u>53-2-201</u>, <u>53-6-111</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE V OUTPATIENT CARDIAC AND PULMONARY REHABILITATION REIMBURSEMENT (1) Exempt hospital and critical access hospital (CAH) interim reimbursement is based on a hospital specific Medicaid outpatient cost to charge ratio, not to exceed 100%. Exempt hospitals and CAHs will be reimbursed their actual allowable costs determined according to ARM 37.86.2803.

- (2) Prospective payment hospitals will be reimbursed on a rate-per-service basis using the outpatient prospective payment system (OPPS) schedules as provided in ARM 37.86.3020.
 - (3) Out-of-state hospitals will not be reimbursed for these services.

AUTH: <u>53-2-201</u>, <u>53-6-111</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE VI INPATIENT HOSPITAL SERVICES, EXCLUSIONS (1) Inpatient hospital services do not include:

- (a) services excluded from coverage by the Medicaid program under ARM 37.85.207;
- (b) experimental or investigational services, clinical trials, off label or non-FDA approved use of drugs, biologicals, and devices;
 - (c) services that do not comply with national standards of medical care; and
- (d) inpatient hospital services provided outside the borders of the United States will not be covered or reimbursed by the Montana Medicaid program.

AUTH: <u>53-2-201</u>, <u>53-6-113</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

RULE VII OUTPATIENT HOSPITAL SERVICES, EXCLUSIONS:

- (1) Outpatient hospital services do not include:
- (a) services excluded from coverage by the Medicaid program under ARM 37.85.207;
- (b) exercise programs and programs primarily educational in nature, including but not limited to:
 - (i) cardiac rehabilitation exercise programs prior to January 1, 2006;
 - (ii) nutritional programs;
 - (iii) independent exercise programs, such as pool therapy, swim programs, or

health club memberships;

- (iv) pulmonary therapy prior to January 1, 2006;
- (c) outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 37.86.601;
- (d) experimental services, clinical trials, off-label or non-FDA approved use of drugs, biologicals, and devices;
 - (e) services that do not comply with national standards of medical care; and
- (f) outpatient hospital services provided outside the borders of the United States will not be covered or reimbursed by the Montana Medicaid program.

AUTH: <u>53-2-201</u>, <u>53-6-113</u>, MCA IMP: <u>53-2-201</u>, <u>53-6-101</u>, MCA

3. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.86.2901 INPATIENT HOSPITAL SERVICES, DEFINITIONS

- (1) through (13) remain the same.
- (14) "Large referral hospital" means an acute care hospital located in the state of Montana that serves as a referral center and has been determined by the department as of April 1, 1993 to have a case mix with a statistically demonstrated level of intensity of care which is higher than the norm for Montana acute care hospitals. Such facilities are Benefis Health Care (Great Falls), Deaconess Medical Center (Billings), Community Medical Center (Missoula), St. James Hospital (Butte), St. Patrick's Hospital (Missoula) and St. Vincent's Hospital (Billings).
 - (15) through (23) remain the same but are renumbered (14) through (22).

AUTH: <u>53-2-201</u>, <u>53-6-113</u>, MCA

IMP: <u>53-2-201</u>, <u>53-6-101</u>, 53-6-111, 53-6-113, 53-6-141, and 53-6-149,

MCA

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, DRG PAYMENT RATE DETERMINATION (1) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:

- (a) through (a)(vi) remain the same.
- (b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which that reflects the cost of hospital resources used to treat cases in that DRG relative to the statewide average cost of all medicaid hospital cases. The relative weight for each DRG is available upon request from Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.
- (c) The department computes a Montana average base price per case. This average base price per case is \$1980 excluding capital expenses, <u>medical</u> education, and disproportionate share hospital payments effective for services

provided on or after from August 1, 2003 through December 31, 2005. For services provided January 1, 2006 through June 30, 2006, the average base price per case is \$2037 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided on or after July 1, 2006, the average base price is \$2118 excluding capital expenses, medical education, and disproportionate share hospital payments.

(d) through (2)(c) remain the same.

(3) The Montana Medicaid DRG relative weight values, average length of stay (ALOS), and outlier thresholds are contained in the DRG table of wWeights and table of weights and thresholds (October 2005) (March 1, 2006). The DRG table of weights and thresholds is published by the department. The department adopts and incorporates by reference the DRG table of wWeights and table table of wWeights and table table of wWeights and table tabl

AUTH: 2-4-201, <u>53-2-201</u>, <u>53-6-113</u>, MCA

IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3002 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) remains the same.

- (2) Outpatient hospital services do not include:
- (a) services excluded from coverage by the Medicaid program under ARM 37.85.207;
- (b) exercise programs and programs primarily educational in nature, including but not limited to:
 - (i) cardiac rehabilitation exercise programs;
 - (ii) nutritional programs;
- (iii) independent exercise programs, such as pool therapy, swim programs or health club memberships;
 - (iv) pulmonary therapy; or
- (c) outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 37.86.601.
- (3) (2) Outpatient hospital services are services that would also be covered by Medicaid if provided in a non-hospital setting and are limited to the following diagnostic and therapeutic services furnished by hospitals to outpatients:
 - (a) through (d)(ii) remain the same.
- (e) diabetic education services provided by a hospital whose diabetic education protocol has been approved by the Medicare Part A Program, P.O. Box 5017, Great Falls, MT 59403. Coverage of diabetic education services is limited to those services meeting the requirements of the Health Care Financing Administration Hospital Manual, CMS Publication 10, Coverage Issues, Appendix Section 80-2, 42 CFR, part 410, subpart H as amended revised through March 27, 2003 October 1, 2005. A copy of this section is adopted and incorporated by reference and is available through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) Outpatient hospital services provided outside the borders of the United States will not be covered or reimbursed by the Montana Medicaid program.

AUTH: <u>53-2-201</u>, <u>53-6-113</u>, MCA

IMP: <u>53-2-201</u>, <u>53-6-101</u>, <u>53-6-111</u>, <u>53-6-113</u>, and <u>53-6-141</u>, MCA

37.86.3005 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT AND QUALIFIED RATE ADJUSTMENT PAYMENT (1) remains the same.

- (2) Outpatient hospital services that are not provided by at exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 will be reimbursed under ARM 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, and [Rule V] for medically necessary services.
 - (3) and (4) remain the same.

AUTH: <u>53-2-201</u>, <u>53-6-113</u>, MCA

IMP: <u>53-2-201</u>, <u>53-6-101</u>, 53-6-111, 53-6-113, 53-6-141, MCA

4. The Department of Public Health and Human Services (department) is proposing changes to the rules governing Medicaid reimbursement for inpatient and outpatient services. The entire 1% increase was applied to reimbursement of hospitals under the prospective payment system (PPS) to partially restore reimbursement rates that were cut in 2002 and 2003. If rates are not increased or realigned, Montana hospitals may not be financially able to offer rapidly changing technologically advanced services in-state. Failure to adopt these changes would result in more Medicaid patients being treated out-of-state. These rule changes would adjust Medicaid Diagnosis Related Group (DRG) reimbursement of hospitals under the PPS. The department uses the DRG prospective payment system to determine reimbursement for many inpatient hospital services. The department is proposing the adoption of an updated DRG Table of Weights and Thresholds effective July 1, 2006 to reflect current charges, services, and medical technology. This change will have an impact on all in-state PPS and border hospitals. Some will be affected positively and some negatively.

The department's proposal for coverage of cardiac and pulmonary rehabilitation therapy and the 1% increase to prospective payment hospitals is based on funding from an appropriation of tobacco tax revenue that took effect January 1, 2006.

ARM 37.86.3002, 37.86.3005, and Rules I, II, III, IV, and V

The department proposes to add two new services, cardiac and pulmonary rehabilitation. Traditionally, Medicaid has not covered these services because they were deemed to be exercise or education. There is, however, strong national data that shows these programs are successful in helping patients better manage their lung diseases or to prevent or lessen the impact of future heart attacks and strokes. When approached by legislators and asked for suggestions on use of I-149 tobacco funds, the department requested funding for these services since tobacco smoking is the cause of many of the diagnoses that require this type of rehabilitation. The

funding is \$385,558 for SFY 2006. Funds would not become available until January 1, 2006, therefore, only six months would be expended. For SFY 2007 the funds are \$403,576. Because of this, the department worked closely with the Montana Association of Cardiovascular and Pulmonary Rehabilitation to determine requirements and necessary caps for services.

Rule VI, VII, and ARM 37.85.3002

The department is proposing these two new rules and amendment of ARM 37.85.3002 regulating outpatient and inpatient hospital services eligible for Medicaid reimbursement to exclude services that are experimental or investigational in nature or are not consistent with national standards of medical care. This proposal is consistent with the definition of "medically necessary service" in ARM 37.82.102 and will make the policy easier to find and read. Out-of-state hospital providers have had difficulty finding the policy on experimental and investigation services. If the proposed rules and amendment are not adopted, confusion will continue to result in payments to which providers are not entitled. Recovery of the payments, also called "overpayments", is expensive for the department and can threaten a provider's financial stability.

ARM 37.86.2901, 37.86.2907, and 37.86.3002

The proposed changes are necessary to assure that high quality hospital services are available to Medicaid recipients in rural communities and to mitigate the shifting of costs from Medicaid to privately insured and privately paying individuals. The proposed changes would implement the legislative funding increases for fiscal years 2006 and 2007. The department did not consider any alternatives to an increase in rates for inpatient hospital services, since the existing rates are not sufficient to fully reimburse hospitals for the cost of providing services to Medicaid recipients and since the legislature appropriated funds for this purpose.

One of the proposed changes to ARM 37.86.2907 would implement a 1% rate increase appropriated by the Montana Legislature, to take effect January 1, 2006. This increase was funded at a total of \$902,406 for both SFY 2006 and SFY 2007. The DRG base amount was computed based on estimated expenditures for the full SFY 2006 even though funds were not available until January 1, 2006.

The other proposed changes are necessary to adjust reimbursement of PPS DRGs to reflect current charges and changes in services provided. The Montana Medicaid payment system for inpatient hospital services must be periodically re-evaluated and updated to maintain that the DRG system remains in good working order. Ideally, this should be done annually. The last time the department evaluated relative weights and cost outlier thresholds was March 2000 to compensate for appropriations. However, they have been adjusted three times since then in March 2001, July 2001, and August 2002. The department intends to rebase the DRG system in October of every year starting October 2007.

Montana's method of payment for inpatient PPS hospital services is prospective payment using the Diagnosis Related Groups (DRG). In most cases, payment equals the relative weight for the DRG times the base price plus all applicable addons, such as medical education, capital, and disproportionate share hospital payments. This payment method is also designed to give hospitals an added measure of financial support to help cover the costs of exceptionally expensive cases by also paying an "outlier" amount. The charges for medically necessary services are multiplied by the cost-to-charge ratio (56%) and then compared to the cost outlier threshold for the appropriate DRG. Costs exceeding the threshold are multiplied by a marginal cost ratio (60%) to determine the outlier reimbursement amount.

Montana Medicaid has chosen to develop its own set of relative weights because Montana's population differs significantly from Medicare's population. Also, because of Montana's sparse population, it is awkward to adopt relative weights that reflect much more urban styles of practice. The recommended relative weights are based on data from inpatient stays in Montana hospitals in SFY 2002 to 2005 that were paid using the DRG system. As of the date of this notice, SFY 2005 claims are still incomplete. The data set includes claims as of June 30, 2005. The geometric mean of the charge amounts for each individual DRG was calculated. These calculated charge amounts were used as the measure to calculate the relative weights. The new relative weights are set so they average to 1.0 for the claims that would be paid on a DRG basis. For example, if a given DRG had geomean charges of \$6,000, and the geomean charge for all DRGs was \$3,000, then that DRG would be assigned a relative weight of 2.0000. Some DRGs had very low volumes. If there were fewer than five cases within the time frame for a particular DRG, then that DRG was made exempt from prospective payment. These DRGs are paid on a state wide cost-tocharge ratio because they are so rare that stable weights cannot be calculated with confidence. A total of 530 valid DRGs were evaluated because 22 DRGs are no longer valid. Of these, 121 DRGs have a "0" relative weight because there were fewer than five cases per DRG.

When claims paid on a DRG basis are unusually expensive, they may become eligible for cost outlier payments. Cost outlier thresholds are set separately for each DRG so that outlier payments will not exceed an average of 10% of the payments for that DRG. The Medicare program aims for a range between 5% and 8%. The cost outlier thresholds are multiples of the DRG rate. The Montana Medicaid program has used this approach since at least 1993. The Medicare program uses a different approach under which the threshold is higher than the DRG rate by a fixed dollar amount that is the same for every DRG. As a rule of thumb, thresholds tend to be between two and four times as high as the DRG payment. The department calculated the proposed cost outlier thresholds by multiplying the gross DRG by four, on a DRG-by-DRG basis. Because cost outlier thresholds are set individually for each DRG and depend on the charges for that group, the thresholds for low-volume DRGs (those DRGs with less than five claims) cannot be calculated with confidence. These DRGs will have no relative weights and will be paid on a cost-to-charge ratio and therefore, will have no cost outlier thresholds.

Some DRGs were separated in the fee schedule that was effective October 2005 by the patient's age and also by whether the patient was treated in a large referral hospital or in another DRG hospital. The size of the hospital was removed as a consideration in the proposed calculations and rule amendments because the department believes that the cost to treat a patient is about the same no matter what the size of the hospital. Also, the determination of which facilities are large referral hospitals has not been updated since 1993. The cost to treat a patient with a mental health diagnosis, DRG 425 through 433, varied widely according to the age of the patient. The Addictive & Mental Disorders Division and the Children's Mental Health Bureau were consulted and the department is proposing that the mental health DRGs would be split by age when calculating the proposed relative weights and the proposed cost outlier thresholds. The relative weight and the cost outlier threshold for DRG 462, Rehabilitation, was negotiated with the rehabilitation facilities in 2004 and will, therefore, not be changed. Using the same methodology as all other DRGs, the relative weight for the rehabilitation DRG, 462, would have been 1.2290 instead of the current 6.0950 and the cost outlier threshold would have been \$9,734 instead of the current \$29,569. The DRG base rate or base price will be increased from \$2037, after the 1% increase, to \$2118 in this proposal to maintain budget neutrality.

Estimated Financial/Budget Impacts

The addition of cardiac and pulmonary rehabilitation services as reimburseable Medicaid services is expected to increase Medicaid expenditures a total of \$385,558 for state fiscal year 2006, however only six months will be expended. Of the total, approximately \$112,930 will be paid by state special revenue funds and \$272,628 by federal special revenue funds. In state fiscal year 2007, the addition of cardiac and pulmonary rehabilitation services are expected to increase Medicaid expenditures a total of \$403,576. Of this, approximately \$120,750 will be paid by state special revenue funds and \$282,826 by federal special revenue funds.

The proposed 1% increase in Medicaid reimbursement to PPS hospital facilities is expected to total \$902,406 for SFY 2006, however only six months will be expended. State special revenue will pay about \$264,324 and federal special revenue will pay about \$638,082 of the total. In state fiscal year 2007, the proposed increase will add a total of about \$902,406 in Medicaid expenditures. Of this, about \$270,009 will come from state special revenue and \$632,397 will come from federal special revenue.

The proposed DRG rebasing should be budget neutral to the SFY 2006 and 2007 appropriations. Although some DRGs will increase, others will decrease. Overall, rebasing DRG weights and thresholds will not affect the Medicaid budget.

5. The department intends that the amendments to ARM 37.86.2907(1)(c) and the changes to ARM 37.86.3002, 37.86.3005, and Rules I, II, III, IV and V are intended to be applied retroactively to January 1, 2006. No detrimental effects are

anticipated as a result. The changes to ARM 37.86.2901, 37.86.2907(1)(b) and (c), 37.86.2907(3), and Rules VI and VII are intended to become effective July 1, 2006.

- 6. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on May 18, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.
- 7. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

/s/ Russ Cater	/s/ Russ Cater for
Rule Reviewer	Director, Public Health and
	Human Services

Certified to the Secretary of State April 10, 2006.